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ABSTRACT

Part of a series on early childhood demonstration programs designed to improve early parent-child relationships, stimulate positive child development, and prevent later behavior difficulties, the pamphlet describes a program in which the waiting room of a pediatric clinic for low-income families is utilized to teach parents to help their preschool children develop intellectually and emotionally. Parents visiting the pediatric clinic with children 20-30 months of age are invited to participate in the playroom program, which teaches them play skills they can use with their children at home. Those who choose to join the program are then asked to come to the playroom on a regular basis, with visits coordinated, whenever possible, with pediatric appointments. Each child initially undergoes a developmental evaluation which serves to identify cognitive handicaps requiring special medical and psychiatric services of the clinic. At subsequent appointments, the playroom trainers work individually with parents, who then use their new skills with their own children. Program aspects reviewed include the basic parent education curriculum, program staffing and staff development, and special resources and facilities. A study of children whose parents completed the program revealed apparent behavioral benefits, and showed that the children gained, on the average, 6 IQ points. (DLS)

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Parent-Child Program Series

Report No. 5

Parent Education in a Pediatric Clinic

National Institute of Mental Health

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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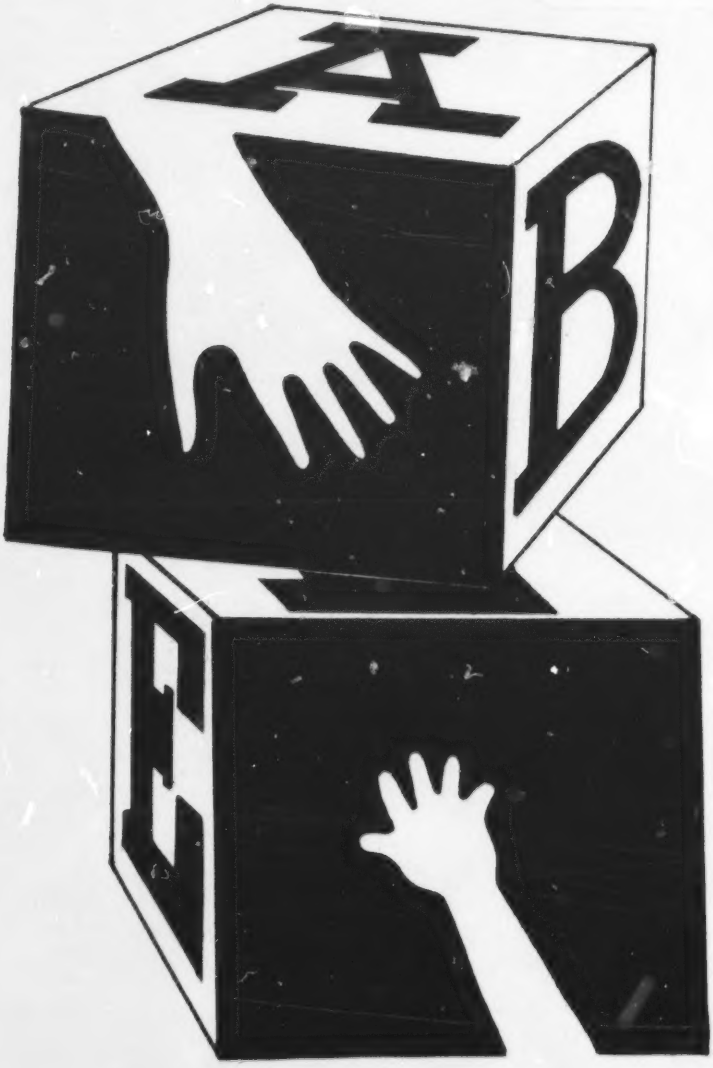

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Parent-Child Program Series

Report No. 5
Parent Education in a Pediatric Clinic

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Preface

Families and Professionals as Partners pamphlets represent an effort on the part of the Center for Studies of Child and Family Mental Health, National Institute of Mental Health, to make visible successful models of programs which enable families to play an important role in improving child mental health. Each pamphlet describes a practical program that can be adapted to local community needs. The present Parent-Child Program Series of five pamphlets describes demonstration programs involving young children from infancy through preschool. The general goals of the series include improving early parent-child relationships, stimulating positive social-emotional development, and preventing later behavior difficulties. This reflects the center's goal of encouraging the utilization of recent research findings by service providers and families to help improve child mental health in their communities.

Joy G. Schulterbrandt
Chief
Center for Studies of Child and Family
Mental Health

PARENT-CHILD PROGRAM SERIES

Introduction

Our Nation's children are a precious but often underdeveloped natural resource. Since the 1960's, social conscience and new scientific insights have converged to spark exploration and demonstration of many new ways to enhance the early years of childhood. Spurred by child development research that marked the preschool years as the cornerstone for subsequent cognitive and emotional development, a number of action and evaluation programs have begun with Federal funding to discover effective ways to stimulate psychological growth in infants and young children. Although many of these programs have been geared toward children from poverty backgrounds, they can help in better development for all children. Head Start, Follow Through, and Sesame Street are among the most famous of these large-scale programs.

Less familiar, perhaps, has been another line of exploration; although more modest in scope, it is comparable in developmental impact: educating parents to work and play with their young children so that their youngsters may grow as thinking, feeling individuals. Many of the programs have been sponsored by the National Institute of Mental Health, which has long recognized that starting children at a very early age on the right developmental footing may prevent later emotional and intellectual problems.

More than a decade of experiment and study has yielded a wealth of parent-involved programs for early childhood enrichment. Their efficacy is well documented. They work—and they can work in new settings and communities as well. The question now is: Will we let them work? Are there people who care enough about children in their own communities to carry these programs forward? We have made great strides as a Nation in providing better opportunities for children to grow up physically healthy. But, for all too many preschoolers, critical formative years are passing without the stimulation and guidance required for healthy emotional and mental development. As innumerable experimental programs have shown, parents can become eager and able teachers of their infants and children once they have learned how to translate their caring into skills and attitudes that actually help their children to develop. Many parents tend to underestimate their young children's abilities because they do not know how to bring them out into the open.

Good parenting does not come automatically with the birth of a child—or even many children. It is a skillful activity that for many takes some training. How to provide that training—in a number of different settings and for somewhat different children—is the subject of this series of pamphlets.

The approaches to parent training reported here grew out of research-demonstration programs supported by the National Institute of Mental Health. Having demonstrated their feasibility and worth, these approaches are now ready for use wherever there are communities willing to make a modest investment that may pay big, long-range dividends for their children. The specific training programs are for the most part relatively simple and inexpensive to implement, and they are likely to offer rich rewards not only to the children but to their parents as well. Because the skills parents acquire are easy to transmit, these programs potentially have a snowball effect: Each parent trained may transmit skills to other children and parents. Once a program has been established, recruitment is often unnecessary. Enthusiastic parents spread the word to others. Over and over these programs have met with great parent support because they provide them with the deeply gratifying ability to help their children make visible progress at home and later at school—often far more than parents thought possible.

This report provides an overview of one approach to parent training, but only its highlights. More detailed information is available. We will describe the program as it was carried out in its original setting as a research-demonstration project, but, as you will see, many variations on the theme are possible, depending on local community needs and resources.

Parent training programs are no panaceas. But they represent needed ways to start young children on the right developmental path—stimulating their curiosity, rewarding their explorations and little triumphs, guiding mind, hand, and eye, indeed the whole child, toward greater understanding, confidence, and competence. Both parents and their young children can learn a form of communication that enriches and delights.

Parent Education in a Pediatric Clinic

The scene is familiar to almost everyone who has ever had a child or visited a pediatric outpatient setting: the waiting room overflowing with restless children, wailing infants, and mothers alternately bored and nervous. In a pediatric clinic, the mother may park some or all of her children in the playroom while she absentmindedly thumbs a long outdated magazine, always waiting.

The waiting seems unavoidable; but couldn't this time be spent more constructively? Anne Morris and Joseph Glick at Mount Sinai Hospital in New York think it can and have shown that parents agree wholeheartedly. There, under the directorship of Anne Morris, the playroom in the pediatric clinic has been transformed from a parking lot for children into a learning laboratory for parents, children, and staff. But, first and foremost, it is a place where a "captive" audience of low-income parents can pick up essential pointers on ways to help their youngsters develop intellectually and emotionally.

The pediatric clinic program was initiated as a demonstration project with funding provided by the National Institute of Mental Health and the Office of Child Development. It capitalizes on the results of many years of early child development research to create a series of experiences for 2- and 3-year-olds that raises their IQ's and may help them later perform well in school. And it does so with the help of the child's most important first teachers, his or her own parents.

Parents visiting the pediatric clinic with children 20 to 30 months of age are personally invited to participate in the "playroom program" that teaches them play skills they can use with their children at home. They are initially interviewed by playroom staff; then, those who choose to join the program are asked to come to the playroom on a regular basis every 2 to 3 weeks for 6 months, with visits coordinated, whenever possible, with pediatric appointments. Parents first are observers while their child undergoes a "developmental evaluation" which serves to identify cognitively handicapped children requiring special medical and psychiatric services of the clinic. At subsequent appointments, the playroom trainers work individually with parents, who then use their new skills with their own children. A given parent will work with the same playroom

trainer throughout the training cycle. Parent and trainer go through a set curriculum which exposes the parent to a progression of play approaches, each of which focuses on a particular toy which the parent may borrow, use at home with the child, and return at the next session. (Some expendable books and toys are given outright.)

Creating and operating such a program require several critical components:

- Low-income parents of 2- and 3-year-olds willing to participate in the training program
- A pediatric setting where they can be recruited and trained
- A playroom where training takes place
- A playroom staff of trainers who recruit and work with the parents
- A training "curriculum" consisting of a special sequence of "exercises" for parents to learn in conjunction with a carefully chosen group of toys
- A program coordinator responsible for establishing and operating the program, for training and supervising the playroom staff, and for assuring that the program is functioning well and integrated into its host setting.

Let us now look at how these components were orchestrated into a model program at its original site in New York, with an eye toward ways it might be adopted and adapted in other communities.

The Basic Parent Education Curriculum

At its core, the program developed at Mt. Sinai Hospital is designed to provide low-income parents with play skills that can help them stimulate their preschool children's cognitive and emotional development. Over the course of the 6-month training period, parents are exposed to 12 exercises which concentrate on the language and perceptual development of their children. Each exercise focuses on the primary features of one toy, such as a stack toy, peg board, or puzzle. The trainers stress ways to interact verbally with young children while labeling, sorting for color or size, and otherwise manipulating toys. They also emphasize the need to give positive reinforcement, by word and/or gesture, as the children progress. Parents are expected to work with their children at home about 15-20 minutes each day, preferably at the same time and place. To guide their home sessions, they are given work sheets describing each exercise.

In transmitting play skills to parents, the trainer first demonstrates the parent role to the parent; then the roles are reversed, with the

trainer pretending to be the child. Role playing as the child, the trainer will deliberately make child-like mistakes to encourage the parent to make appropriate corrections. Over time, a free exchange develops between trainer and parent as they discuss such issues as differences between adult and child learning patterns, the uses of praise and reinforcement, the age appropriateness and educational value of toys, and the competencies to be expected of children of different ages.

As described by Anne Morris and Joseph Glick, the exchange between trainers and parents covers many strategies for enhancing children's development:

> The program emphasizes the importance of the parent-teacher providing the child with rational explanations and optional solutions as part of his learning experiences during play activities. Parents are advised to attach words to actions because the children require direction and instruction to learn. The mother becomes aware that the concepts her child learns, such as matching colors, are the result of a particular interaction she began by directing the child's attention to certain features of a toy. Although the activities are play for the child they are not random behavior for the parent, who becomes aware of the cognitive needs of her child at different stages of development.
>
> The structured teaching method . . . shows parents that there are alternative ways to approach children. They are encouraged to seek out those techniques that work best for their child at a particular stage of development.
>
> . . . [When a playroom assistant role-plays as a child], it prepares parents for normal behaviors they have to react to at home. For example, by placing a round block in a square hole the trainer demonstrates that a child will not always learn a task the first time and may have to repeat a particular behavior many times before he really understands it. This leads to a discussion of what kinds of behaviors to expect at different ages. [Parents learn that] inconsistencies in behavior are not "bad" but part of the discovery process involved in learning. The value of praise is stressed as a means of encouraging the child to attempt to master new skills. During role-playing, methods of positively reinforcing learning behaviors are demonstrated.
>
> . . . The 12 sequentially graded exercises for each age group concentrate on perceptual-motor and language skills and problem solving. Each toy selected has a primary feature so that parents with limited education experiences can immediately perceive the relationships of the different elements. For

example, the openings in the shape box indicate clearly where each differently shaped block is to be placed. . . . The activities for each exercise are broken down into small steps that lead to a goal such as matching colors or shapes.

After the third training session, the parent is asked to demonstrate with her child the use of a toy they have recently played with together. The trainer and program supervisor, who both observe this demonstration session, subsequently discuss progress and problems with the parent. This session provides material for subsequent supervisory sessions aimed at making parent training more effective. A second demonstration session occurs after the seventh session, but is observed only by the trainer. This, too, serves as a basis for discussion and corrective feedback for the parent and allows the trainer to evaluate the progress of parent and child.

At the end of the training period, all parents in the training group are invited to a special "graduation" party to celebrate their having completed the program. Diplomas are awarded, for some parents one of the few tangible signs of achievement they ever have obtained.

Program Staffing and Staff Development

Mounting such a program in an existing pediatric clinic naturally requires the cooperation of existing staff. The program's initiators found that staff members, once they understood the program's purpose, were likely to welcome it and aid in recruiting parents to come.

In the demonstration project, those specifically charged with carrying out the parent training, namely the playroom staff members, had to be specially trained to shift their orientation from working directly with children to working first with parents. However, the reorientation was not difficult. The playroom staff members received from 4 to 6 weeks training in the use of the curriculum, working both individually and with other staff members. Since written materials were not used when teaching, staff members memorized the curriculum. The project director observed each staff member before she worked with parents, monitored staff periodically, and conducted weekly staff meetings to demonstrate teaching methods.

The initial demonstration project was carried out with a service staff of one supervisor, three playroom assistants, and a program secretary. The size of playroom staff can be altered, depending on the size of the population to be served.

Special Resources and Facilities

The parent training program described here has been successfully implemented as a research-demonstration program in three different pediatric settings, including a pediatric clinic in which an existing playroom was used and a community-based child health station in which a playroom was established and staffed. The program seems to work best when the playroom is designed with an open plan, so that it is readily accessible and visible to parents as they sit in the waiting area. This setup provides an opportunity for parents to see other parents participating and is reassuring to parents and children alike.

The program does not necessarily require the use of an existing playroom. Most pediatric outpatient care settings have some unused corner in which a demonstration play area can be set up and used for training. At a minimum, space is required for some toy storage and shelving, with sufficient room for one trainer-parent pair to sit down and "play" together.

Because the program curriculum is built around the use of specific toys which are loaned to parents, there must be an ample duplicate supply to allow for demonstrations, loans, and loss. Dr. Morris has written a manual describing the establishment and operation of a pediatric clinic playroom program which provides specific suggestions on the selection and use of toys in the curriculum for children of different ages (see page 9).

Program Impact

In its initial pediatric clinic setting in New York, the program was very well received by the predominantly low-income Puerto Rican and black parents who used the pediatric clinic. The program was conducted bilingually throughout, from recruitment through the graduation ceremony, to assure that the Spanish-speaking parents would be able to participate fully. Such a program is likely to be of interest to many other parent populations as well, including middle-class parents, who have been shown to be highly receptive to many child-development programs originally intended for use with less advantaged populations.

Staff of the demonstration program found that, although it is relatively easy to obtain agreement from parents to participate in the program, only about half of all who begin the training sessions are likely to complete them.

The demonstration program at Mt. Sinai Hospital showed that:

1. Parents are willing and able to participate in such a training

program, even when it requires extra trips to the clinic with their children.

2. Parents react enthusiastically to the training provided. The first training group requested and was given a continuing group training program which enabled them to develop their skills further and to discuss child-rearing problems and solutions with one another and staff members.
3. Children react positively to the new toys and skills their parents bring home. In the demonstration project, a study of children whose parents completed the program (both in the Mt. Sinai setting and in a child health clinic) showed that they gained, on the average, six IQ points, while a comparable group of children whose parents were not yet in the program showed no IQ changes. Children from "late-entry" families, whose parents subsequently completed the program, showed comparable gains.
4. The program apparently also brought behavioral benefits to the children. As the project's originators report:

   > However, IQ was not the only measure to assess program effects. Reports from nursery schools, Head Start programs, and parents about the children's adjustment to school proved to be of equal interest. Unbiased teachers compared treated children (those whose parents had participated in the pediatric clinic program) to untreated children from comparable backgrounds. They reported that treated children adjusted extremely well to the classroom. Their program experiences gave them skills in handling materials and allowed them to participate more effectively in school activities than untreated children. A measure of our success was the number of requests from preschool program directors who asked permission to refer parents with younger siblings for treatment.

5. The program helps parents to accept greater responsibility for their role as their children's teachers:

   > Parents consistently reported behavioral changes in their children, including an increase in attention and improved cooperation with other children. Gains in concept attainment, e.g. learning about shapes and colors, were also mentioned. . . . They said the program had helped them as well as their children to learn, and then added that education was their responsibility as well as the teachers'. *Thus, the major impact of this minimal program may relate to changes in the parent's view of herself as the primary educator of her child.*

For Further Information

A practical guide to establishing similar pediatric clinic playroom programs, "How to Set Up an Educational Intervention Program in a Pediatric Clinic," written by Dr. Morris, is available through ERIC. It includes suggestions for organizing and operating such a program, selecting toys and arranging the playroom, and selecting and training staff, and it provides curricular guides as well.

Additional information on the project and its research evaluation can be obtained by writing to:

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